Chemotherapy Services [Refer to WAC 388-531-0950(11)]

Bill the appropriate chemotherapy administration CPT® code for each drug administered.

The Department's chemotherapy administration policy is as follows:

- Providers may bill chemotherapy administration (CPT codes 96411 or 96417) and bill one administration for each drug given. The administration and drug must be billed on the same claim.

- The Department pays for only one "initial" drug administration code (CPT code 96409 or 96413) per encounter unless:

  - ✓ Protocol requires the use of two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second "initial" service code with modifier -59.

- The Department does not pay for Evaluation and Management (E&M) CPT code 99211 on the same date of service as the following drug administration codes: 96401-96549. If billed in combination with one of these drug administration codes, the Department will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable E&M service was provided. If modifier 25 is not used, the Department will deny the E&M code.

- **Items and Services Not Separately Payable with Drug Administration:**
  Some items and services are included in the payment for the drug administration service, and the Department does not pay separately for them. These services include, but are not limited to:

  - ✓ The use of local anesthesia;
  - ✓ IV start;
  - ✓ Access to indwelling IV (a subcutaneous catheter or port);
  - ✓ A flush at conclusion of an infusion;
  - ✓ Standard tubing; and
  - ✓ Syringes and supplies.

- **Infusion vs. Push:**
  An intravenous or intra-arterial push is defined as:

  - ✓ An injection in which the health care professional who administers the substance or drug is continuously present to administer the injection and observe the patient; OR
  - ✓ An infusion of 15 minutes or less.

Note: You must bill drug, infusion, and injection codes on the same claim form.

Chemotherapy Drugs

The following payment guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- The Department's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- The Department's maximum allowable fee is equal to Medicare's drug methodology of 106% of the average sales price. If a Medicare fee is unavailable for a particular drug, the Department will continue to price the drug at 86% of average wholesale price (AWP).
- Preparation of the chemotherapy drug is included in the payment for the administration of the drug.

Note: Refer to Section K of these billing instructions for information on when it is necessary to bill the Department for a chemotherapy drug using an unlisted drug code.

Billing for Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, the Department pays providers for the total number of units contained in the vial. **For example:**

If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is paid. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If the Department's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, the Department pays providers for only the amount of drug administered to the client. **For example:**

If a total of 750 mg of Cytarabine is required for the therapy, and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is paid. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If the Department's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

Oral Anti-Emetic Drugs

In order to bill the Department for oral anti-emetic drugs (HCPCS codes Q0163-Q0181), the drug must be:

- Part of a chemotherapy regimen;
- Administered or prescribed for use immediately before, during, or within 48 hours after administration of the chemotherapy drug;
- Billed using one of the ICD-9-CM diagnosis codes140.0-208.90, 230.0-239.9, or V58.1; and
- Submitted on the same claim form with one of the chemotherapy drug codes (HCPCS codes J8530-J9999).

Hydration Therapy with Chemotherapy

Intravenous (IV) infusion of saline (CPT codes 96360-96371) is not paid separately when administered at the same time as chemotherapy infusion (CPT codes 96413- 96417). Separate payment is allowed for IV infusion when administered separately from the chemotherapy infusion. In this case, bill using the IV infusion code with modifier 59.

Surgical Services [Refer to WAC 388-531-1700]

Providers must check the Physician-Related Services Fee Schedule for those surgical services that require either PA or EPA.

Global surgery payment includes all the following services:

- The surgical procedure;
- For major surgeries (90-day global period), preoperative visits (all sites of service) that occur the day before or the day of the surgery;
- For minor surgeries (less than 90-day global period), preoperative visits (all sites of service) that occur on the day of surgery;
- Services by the primary surgeon (all sites of service) during the postoperative period;
- Postoperative dressing changes, including:
  - ✓ Local incision care and removal of operative packs;
  - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - ✓ Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; and
  - ✓ Change and removal of tracheostomy tubes.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

Note: Casting materials are not part of the global surgery policy and are paid separately.

Global Surgery Payment

- The global surgery payment period applies to any provider who participates in the surgical procedure. These providers include:
  - ✓ The surgeon;
  - ✓ The assistant surgeon (modifiers 80, 81, or 82);
  - ✓ Two surgeons (modifier 62);
  - ✓ Team surgeons (modifier 66); and
  - ✓ Anesthesiologists and CRNAs.

- The following procedure codes are bundled within the payment for the surgical procedure during the global period. Do not bill these codes separately unless one of the conditions on the following page exists:

Procedure Code	Summary of Description
E&M Services	
99211-99223	Office visits, initial hospital observation care, and initial hospital inpatient care
99231-99239	Subsequent hospital care, observation or inpatient care services, and hospital discharge services
99241-99245	Office consultations
99291-99292	Critical care services.
99307-99310	Subsequent nursing facility care
99324-99337	Domiciliary, rest home, or custodial care services
99347-99350	Home services
Ophthalmological Services	
92012-92014	General ophthalmological services

The E&M codes listed above may be allowed if there is a separately identifiable reason for the additional E&M service unrelated to the surgery. In these cases, the E&M code must be billed with one of the following modifiers:

Modifier **Description**

- 24 Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)

- 25 Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)

- 57 Decision for surgery (only applies to surgeries with a 90-day global period)

- 79 Unrelated procedure or service by the same physician during the postoperative period

- Professional inpatient services (CPT codes 99221-99223) are payable only during the global follow-up period if they are performed on an emergency basis (i.e. they are not payable for scheduled hospital admissions).

- Bundled procedure codes are not payable during the global surgery payment period.

- A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.

- Providers who perform only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level E&M code. These services are not included in the global surgical payment.

- The provider who performs the emergency room service must bill for the surgical procedure without using modifier 54.

- Preoperative and postoperative critical care services provided during a global period for a seriously ill or injured client are not considered related to a surgical procedure and are paid separately when all of the following apply:

  - ✓ The client is critically ill or injured and requires the constant attendance of the provider;
  - ✓ The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
  - ✓ The client is potentially unstable or has conditions that could pose a significant threat to life or risk of prolonged impairment.

  Bill the appropriate critical care codes with either modifier 24 or 25.

- The Department allows separate payment for:

  - ✓ The initial evaluation to determine need for surgery;
  - ✓ Preoperative visits that occur two or more days before the surgery. Use the specific medical diagnosis for the client. Do not use V72.83-V72.85;
  - ✓ Postoperative visits for problems unrelated to the surgery;
  - ✓ Postoperative visits for services that are not included in the normal course of treatment for the surgery; and
  - ✓ Services of other providers, except when more than one provider furnishes services that are included in a global package (see modifiers 54 and 55).

Department-Approved Hospitals for Bariatric Surgery

See Section I for information on bariatric surgery.

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill the Department for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to the Department along with the Core Provider Agreement:

  ✓ Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
  ✓ Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
  ✓ Certification as an RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **are not required** to submit the Certification as an RNFA from the Certification Board Perioperative Nursing.

Multiple Surgeries

When multiple surgeries are performed on the same client, during the same operative session, The Department pays providers as follows:

- 100% of the Department's maximum allowable fee for the most expensive procedure; plus,
- 50% of the Department's maximum allowable fee for each additional procedure.

To expedite payment of your claims, bill all surgeries performed during the same operative session on the same claim.

If a partial payment is made on a claim with multiple surgeries, providers must adjust the paid claim using a Department Adjustment Request form, DSHS 525-109. Refer to Important Contacts page for information on ordering/downloading Department forms.

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.

- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.

- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.

- The Department does not pay for an E&M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If it is appropriate to bill the E&M code, use modifier 25.

Other Surgical Policies

- Use modifiers 80, 81, and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).

- ***Microsurgery Add On Code 69990***
  CPT indicates that code 69990 is not appropriate when using magnifying loupes or other corrected vision devices. Also, code 69990 is not payable with procedures where use of the operative microscope is an inclusive component of the procedure (i.e. the procedure description specifies that microsurgical techniques are used).

  The Department follows CCI guidelines regarding the use of the operating microscope. Do not bill code 69990 in addition to procedures where the use of the operating microscope is an inclusive component.

- The Department pays for the following procedure codes which include breast removal and breast reconstruction for clients who have breast cancer or history of breast cancer, burns, open wound injuries, or congenital anomalies of the breast. The following list of diagnosis codes must be used; **otherwise the service requires prior authorization (PA)**.

- Removal of failed breast implants with ICD-9-CM diagnosis code 996.54 requires PA. The Department will pay to remove implants (CPT codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.

- The Department requires EPA for reduction mammoplasties (CPT code 19318) and for mastectomy for gynecomastia for men (CPT code 19300). See section I for more information.

CPT Code(s)	Brief Description	Limitations
11920-11921	Correct skin color defects (use V10.3) (Tattoo)	Limited to ICD-9-CM diagnoses: ✓ V10.3 ✓ 174.0-175.9 ✓ 233.0 ✓ 757.6 ✓ 759.9 ✓ 879.0-879.1 ✓ 906.0 ✓ 906.8 ✓ 942.00-942.59
11960	Insertion of tissue expander(s)	
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19301	Removal of breast tissue	
19302	Remove breast tissue, nodes	
19303	Removal of breast	
19304	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	
S2066	Breast reconstruction w/gap flap	
S2067	Breast reconstruction	

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.10 and 633.11).

- Modifier 53 must be used when billing for incomplete colonoscopies (CPT code 45378, or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 or HCPCS codes G0105 or G0121. It is "informational only" for all other surgical procedures.

Surgical Treatment for Sleep Apnea

The Department requires PA for surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS) (see procedures listed below) when billed with diagnosis code 327.23 (obstructive sleep apnea) or 780.57 (unspecified sleep apnea):

- 21199;
- 21685;
- 42120;
- 42140;
- 42145;
- 42160; or
- 42299.

Epiphyseal

Epiphyseal surgical procedures (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not paid when billed with enterostomy procedures (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140-44147).

Angioscopy

The Department pays for one unit of angioscopy (CPT code 35400), per session.

Medical Policy Updates

In accordance with WAC 388-501-0055, the Department has reviewed the recommendations of the health technology assessment clinical committee (HTACC) (RCW 70.14.080 through 70.14.140) and has made the decision to adopt recommendations for the following technologies:

- Knee Arthroscopy
- Artificial Disc Replacement
- Transcutaneous Electrical Nerve Stimulation (TENS) device
- Drug Eluting Stents
- Bone Growth Stimulators
- Computed Tomography Angiography (CTA)
- Implantable Infusion Pumps

For additional details and medical necessity criteria, go online at:
http://www.hta.hca.wa.gov/assessments.html

Knee Arthroscopy for Osteoarthritis

The Department does not recognize lavage, debridement and/or shaving of the knee (CPT 29877) as medically necessary when these are the only procedure(s) performed during the arthroscopy. Under the above circumstances CPT Code 29877 is not reimbursable. The Department will pay for arthroscopies done for other diagnostic and therapeutic purposes.

Artificial Disc Replacement

The Department pays for Cervical Disc Replacement medical necessity criteria are met and requires prior authorization (PA). CPT codes 22856 and 22861.

The Department pays for Lumbar Disc Replacement medical necessity criteria are met and requires prior authorization (PA). CPT codes 22857, 22862, and 22865.

Transcutaneous Electrical Nerve Stimulation (TENS) device

Effective for dates of service on and after April 1, 2010, the Department does *not* cover TENS devices, related supplies and services for independent home-use.

Drug Eluting Stents

The Department will pay for drug eluting stents when the medical necessity criteria are met and requires EPA. See Section I for Expedited Prior Authorization (EPA) Criteria.

Bone Growth Stimulators

The Department will pay for bone growth stimulators when medical necessity criteria are met and requires prior authorization (PA). CPT codes 20974, 20975 and 20979.

Computed Tomography Angiography (CTA)

The Department will pay for CTA when the medical necessity criteria are met and requires PA. CPT code 75574 is restricted to POS 21, 22, 23

Implantable Infusion Pumps or Implantable Drug Delivery Systems (IDDS)

The Department will pay for CPT codes 62318, 62319, 62350, 62351, 62360, 62361 when medically necessary and only for the indications below:

- Cancer pain
- Spasticity

> Note: Implantable drug delivery systems (Infusion Pump or IDDS) are not considered medically necessary for treatment of chronic pain not related to cancer.

Apheresis

Therapeutic apheresis (CPT codes 36511-36516) includes payment for all medical management services provided to the client on the date of service. The Department pays for only one unit of either CPT code per client, per day, per provider.

Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless they are billed with modifier 25:

- Established patient office and other outpatient visits (CPT codes 99211-99215); and
- Subsequent hospital care (CPT codes 99231-99233).

Do not bill apheresis management when billing for critical care time (CPT codes 99291-99292).

Bilateral Procedures

- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure with modifier 50. Bill as a single line item on the claim.
- If a procedure is done bilaterally and is identified by its terminology as bilateral (e.g. CPT codes 27395 or 52290), do not bill the procedure with modifier 50.
- Use modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, and 56 are used.

The Department has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, the Department uses a payment split of 10% / 80% / 10% if the above modifiers are used.

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	69%	21%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37788	Cardiovascular	09%	84%	07%
37790 - 37799	Cardiovascular	08%	83%	09%
38100 - 38115	Hemic/Lymphatic	11%	73%	16%
38120 - 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 - 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 - 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	60%	23%
60000 - 60605	Endocrine	09%	82%	09%
60650 - 60699	Endocrine	09%	84%	07%
61000 - 64999	Nervous System	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Urology

Circumcisions (CPT codes 54150, 54160, and 54161)

Circumcisions are covered when billed with one of the following diagnoses:

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balnitis Xerotica (ICD-9-CM 607.81).

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

Refer to Section K for those urinary tract implants covered by the Department. **All services provided and implant codes must be billed on the same claim form**

Urological Procedures with Sterilizations in the Description

These procedures may cause the claim to stop in the Department's payment system and trigger a manual review as a result of the Department's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, you must note one of the following in the *Comments* section of your claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Indwelling Catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- The Department pays providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the post-operative period of a major surgery.

Osteotomy Reconstruction

Procedure Code	Brief Description	Does not require PA when billed with ICD-9-CM diagnoses
21198		170.1 or 802.20 – 802.35

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- The Department requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Do **not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- The Department pays for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- The Department pays providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with the Department to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. An example of this includes, but is not limited to, the time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. The Department has assigned flat fees for these codes.

- The Department does not adopt any ASA RVG codes that are not included in the CPT book. Bill all anesthesia codes according to the descriptions published in the current CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, the Department follows CPT code descriptions.

- The Department does not pay providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT codes.**

  ***Exception*:** Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are paid as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01965 or 01966), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- When billing the following procedures, use only the codes indicated below:

  - ✓ Vasectomies: 00921 (not covered for clients on the TAKE CHARGE program);
  - ✓ Hysterectomies: 00846, 00944, 01962-01963, or 01969;
  - ✓ Sterilizations: 00851; and
  - ✓ Abortions: 01965 or 01966.

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, the Department pays each provider 50% of the allowed amount. The Department limits payment in this circumstance to 100% of the total allowed payment for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. The Department calculates the base units.

Regional Anesthesia

- Bill the Department the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. The Department determines payment by using the procedure's maximum allowable fee, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the global surgical package and is not paid separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- The Department follows Medicare's policy of not paying surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate payment** for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.

- When billing for anesthesia services using CPT **unlisted anesthesia code 01999**, **providers must attach documentation** (operative report) **to their claim** indicating what surgical procedure was performed that required the anesthesia, in order to receive payment. The Department will determine payment amount after review of the documentation.

Anesthesia for Maternity **[Refer to WAC 388-531-0300(9)]**

- The Department pays a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

  Exception: The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962-01966 or 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 5 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

  For Example: When a physician starts a planned vaginal delivery (CPT code 01967) and it results in a cesarean delivery (CPT code 01968), both of these procedures may be billed. However, if both an anesthesiologist and a certified registered nurse assistant (CRNA) are involved, each provider bills only for those services he/she performed. The sum of the payments for each procedure will not exceed the Department's maximum allowable fee.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- The Department's current anesthesia conversion factor is $21.20.
- Anesthesia time is paid using **one minute per unit**.
- Total anesthesia payment is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in **total minutes** only, rounded to the next whole minute. Do not bill the procedure's base units.

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation	
A.	Multiply base units by 15.
B.	Add total minutes to value from step A.
C.	Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D.	Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Anesthesia for Dental

General anesthesia is allowed when provided by an anesthesiology provider for dental admissions. To bill for dental anesthesia, providers must use CPT anesthesia **code 00170** with the appropriate anesthesia modifier.

Refer to the appropriate Department dental billing instructions for information on billing for office-based anesthesia for dental procedures. Download any of the Department's current dental billing instructions at: http://hrsa.dshs.wa.gov/ProvRel/Dental/Dental.html.

Note: Bill the Department directly for dental anesthesia for all clients, including those enrolled in a Department managed care plan.

Teaching Anesthesiologists

The Department pays teaching anesthesiologists for supervision of anesthesiology residents as follows:

- When supervising ***one*** resident only, the teaching anesthesiologist must bill the Department the appropriate anesthesia procedure code with **modifier AA**. Payment to the teaching anesthesiologist will be 100% of the allowed amount.

- When supervising ***two or more*** residents concurrently, the teaching anesthesiologist must bill the Department the appropriate anesthesia procedure codes with **modifier QK**. Payment to the teaching anesthesiologist will be 50% of the allowed amount for each case supervised.

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using the Department's-assigned maximum allowable fee for the procedure code.

- When billing for pain management and other services that are payable using the Department's-assigned maximum allowable fee, do not use anesthesia modifiers. The Department denies claims for these services billed with an anesthesia modifier.

- Two postoperative procedures for pain management are allowed during the same inpatient stay. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

Due to copyright restrictions, the Department publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.

The listings shown below are not guaranteed to be all-inclusive and are provided for convenience purposes only.

The codes listed in the following table with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier 59 with any of these procedure codes.

Procedure Code	Brief Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspirate/inj ganglion cyst
27096	Inject sacroiliac joint
61790*	Treat trigeminal nerve
62264*	Epidural lysis on single day
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273*	Treat epidural spine lesion
62280*	Treat spinal cord lesion
62281*	Treat spinal cord lesion
62282*	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310*	Inject spine c/t
62311*	Inject spine l/s (cd)
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath l/s (cd)
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal cath
62360*	Insert spine infusion device
62361*	Implant spine infusion pump
62362*	Implant spine infusion pump
62365*	Remove spine infusion device

Procedure Code	Brief Description
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63685*	Implant neuroreceiver
63688*	Revise/remove neuroreceiver
64400*	Injection for nerve block
64402*	Injection for nerve block
64405*	Injection for nerve block
64408*	Injection for nerve block
64410*	Injection for nerve block
64412*	Injection for nerve block
64413*	Injection for nerve block
64415*	Injection for nerve block
64416*	Injection for nerve block
64417*	Injection for nerve block
64418*	Injection for nerve block
64420*	Injection for nerve block
64421*	Injection for nerve block
64425*	Injection for nerve block
64430*	Injection for nerve block
64435*	Injection for nerve block
64445*	Injection for nerve block
64446*	Injection for nerve block
64447*	Injection for nerve block
64448*	Injection for nerve block
64449*	Injection for nerve block
64450*	Injection for nerve block

Procedure Code	Brief Description
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve, face muscle
64613*	Destroy nerve, spine muscle
64620*	Injection treatment of nerve
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on
64630*	Injection treatment of nerve
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve

Procedure Code	Brief Description
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76496	Fluoroscopic procedure
77001	Fluoroguide for vein device
77002	Needle localization by xray
77003	Fluoroguide for spine inject
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refil & main

These codes are paid as a procedure using the Department's maximum allowable fee, not with base units and time.

Major Trauma Services

Increased Payments for Major Trauma Care

The legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the Department of Social and Health Services (the Department) receive funding from the TCF to help support provider groups involved in the state's trauma care system. The Department uses its TCF funding to draw federal matching funds. The Department makes supplemental payments to designated trauma centers and pays enhanced rates to physicians for trauma cases that meet specified criteria.

The enhanced rates are available for trauma care services provided to fee-for-service Medical Assistance clients with Injury Severity Scores (ISS) of 13 or greater for adults and 9 or greater for pediatric (under 15 years of age).

TCF Payments to Hospitals

A **hospital** is eligible to receive TCF payments from the Department if the hospital:

- Is designated by DOH as a trauma service center (or "recognized" by DOH if in a bordering city);
- Is a Level 1, Level 2, or Level 3 designated trauma service center;
- Meets the provider requirements in WAC 388-550-5450 and other applicable WAC;
- Meets the billing requirements in WAC 388-550-5450 and other applicable WAC; and
- Submits all information DOH requires to ensure trauma services are being provided.

For a list of the Designated Trauma Services, check DOH's website at:
http://www.doh.wa.gov/hsqa/emstrauma/download/designation_list.pdf

TCF Payments to Physicians

Physicians and other clinical providers who are members of Designated Trauma Services receive TCF payments from the Department:

1) For "qualified" trauma care services. Qualified trauma care services are those that meet the ISS specified in subsection (3) below. Qualified trauma care services also include inpatient rehabilitation and surgical services provided to fee-for-service clients within six months of the date of the qualifying injury when the following conditions are met:

   (a) The follow-up surgical procedures are directly related to the initial injury;

   (b) The follow-up procedures were planned during the initial acute episode of injury; and

   (c) The plan for the follow-up surgical procedure(s) is clearly documented in the medical record of the client's original hospitalization for the traumatic injury.

2) For hospital-based services only, except as specified in subsection (4).

3) Only for trauma cases that meet the ISS of:

   (a) Thirteen or greater for an adult trauma patient (a client age fifteen or older); or
   (b) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).

4) On a claim-specific basis. Services must have been provided in a designated trauma service center, except that qualified follow-up surgical care within six months of the initial traumatic injury, as described in subsection (1) above, may be provided in other approved care settings, such as ambulatory surgery centers.

5) At a rate determined by the Department. The enhanced rates are subject to the following limitations:

   (a) The Department monitors the payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the biennium will not exceed the legislative appropriation for that biennium.

   (b) Laboratory and pathology charges are not eligible for enhanced payments from the TCF.

TCF Payments to Hospitals and Physicians in Transfer Cases

When a trauma case is transferred from one hospital to another, the Department makes TCF payments to physicians and other eligible clinical providers, according to the ISS score as follows:

- If the transferred case meets or exceeds the appropriate ISS threshold (ISS of 13 or greater for adults, and 9 or greater for pediatric clients), **both** transferring and receiving hospitals and the eligible providers on their teams who furnished qualified trauma services are eligible for increased payments from the TCF. The transfer must have been to a higher level designated trauma service center, and the transferring hospital must be at least a level 3 hospital. Transfers from a higher level to a lower level designated trauma service center are not eligible for the enhanced payments.

- If the transferred case is below the ISS threshold, only the **receiving** hospital and the eligible providers on its team who furnished qualified trauma services are eligible for increased payments from the TCF. The receiving hospital and clinical team are eligible for enhanced payments regardless of the ISS for the transferred case.

Payment

Physicians and clinical providers are paid on a claim-specific basis for the qualified trauma care services they provide. The Department uses the lesser of its maximum allowable fee or the billed amount as the base rate to which the enhancement percentage is applied.

Hospitals receive a percentage of a periodic payment amount. Each hospital's percentage of the periodic payment amount depends on the total qualified trauma care provided by the hospital for the state fiscal year to date, measured against the total qualified trauma care provided by designated Levels 1-3 hospitals during the same period.

The total payments from the TCF for a biennium cannot exceed the TCF amount appropriated by the legislature for that biennium. The Department has the authority to take whatever actions are needed to ensure it stays within the current TCF appropriation.

The Department distributes TCF payments to eligible providers who submit trauma claims with the appropriate trauma modifier or claim identifier within the time frames specified by the Department.

Each qualifying trauma service and/or procedure on the physician's or other clinical provider's claim is paid at the lesser of the Department's current fee-for-service (FFS) rate, or the billed amount, multiplied by the TCF enhancement percentage. Charges for laboratory and pathology services and/or procedures are not eligible for enhanced payments from the TCF and are paid at the lesser of the Department's current FFS rate or the billed amount.

Claims Excluded from Enhanced Payment for Trauma Services

Claims for trauma care provided to clients enrolled in the Department's managed care organizations are **not** eligible for increased payments from the TCF.

Laboratory and pathology charges are **not** eligible for increased payments from the TCF.

Billing

To bill the Department for qualified trauma care services provided by physicians and clinical providers, add modifier **ST** to the appropriate procedure code. The modifier ST ***must*** be entered on the CMS-1500 Claim Form to receive the enhanced payment.

If it is necessary to bill using two or more modifiers on a detail line and modifier 26 (professional component) is one of the modifiers:

- Bill modifier ST in the first modifier field; and
- Modifier 26 (professional component) in the second modifier field.

Bill all other multiple modifier combinations by using modifier 99 in the first modifier field, modifier ST in the second modifier field, and other applicable modifiers in the third and fourth modifier fields. Billing all payment modifiers with modifier 99, except the modifier ST/26 combination, ensures appropriate payment.

Adjusting Trauma Claims

The Department considers a provider's request for a TCF claim adjustment only if the Department receives the adjustment request within one year from the date of service on the initial claim.

The Department does not make any TCF payment for an otherwise eligible claim when the request to adjust such a trauma claim for purposes of getting enhanced payment is received by the Department beyond 365 calendar days from the date of service. See WAC 388-502-0150 for other time limits applicable to trauma claims.

All claims and claim adjustments are subject to federal and state audit and review requirements.

Injury Severity Score (ISS)

> **Note:** The current ISS qualifying score is 13 or greater for adults, and 9 or greater for pediatric clients (through 14 years of age only).

The ISS is a summary severity score for anatomic injuries.

- It is based upon the Abbreviated Injury Scale (AIS) severity scores for six body regions:
  - ✓ Head and neck;
  - ✓ Face;
  - ✓ Chest;
  - ✓ Abdominal and pelvic contents;
  - ✓ Extremities and pelvic girdle; and
  - ✓ External.
- The ISS values range from 1 to 75.
- Generally, the higher the score, the more serious are the patient's injuries.

For Additional Information

Please see numbered memorandum number 03-53-MAA for additional information.

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

Department of Health
Office of Emergency Medical & Trauma Prevention
1-360-236-2871 or 1-800-458-5281.

For information on **payment**, contact:

Office of Hospital Rates
Medicaid Purchasing Administration
1-360-725-1835

For information on a specific **Medicaid trauma claim**, contact:

Provider Relations Unit
1-800-562-3022, option 2

PHYSICIAN/CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Cardiologist
Certified Registered Nurse Anesthetist
Critical Care Physician
Emergency Physician
Family/General Practice Physician
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Note: Many procedures are not included in the enhanced payment program for major trauma services.